State of Hawaii
Department of Health
Adult Mental Health Division

Addendum Number 2

March 24, 2006

To

Request for Proposals

RFP No. HTH 420-4-06
Outpatient Treatment and Clubhouse Services for the Waianae Coast

March 3, 2006

March 24, 2006

ADDENDUM NO. 2

To

REQUEST FOR PROPOSALS
Outpatient Treatment and Clubhouse
Services for the Waianae Coast
RFP No. HTH 420-4-06

The Department of Health, Adult Mental Health Division, is issuing this addendum to RFP Number HTH 420-6-06, Outpatient Treatment and Clubhouse Services for the Waianae Coast, for the purposes of:

☒ Responding to questions that arose at the orientation meeting of March 10, 2006 and written questions subsequently submitted in accordance with Section 1-V, of the RFP.

☐ Amending the RFP.

The proposal submittal deadline:

☐ is amended to <new date>.

☒ is not amended.

Enclosed is (are):

☒ A summary of the questions raised and responses for purposes of clarification of the RFP requirements.

☐ Amendments to the RFP.

Should you have any questions, contact:
Ray Gagner, RFP Contact Person
Hawaii Department of Health
1250 Punchbowl Street, Room 256
Honolulu, Hawaii 96813

Tel.: (808) 586-4688
Email: rlgagner@amhd.health.state.hi.us

Responses to Question Raised by Applicants For RFP No. HTH 420-4-06
Outpatient Treatment and Clubhouse Services for the Waianae Coast

1. Question:

A number of general questions regarding the RFP development process were submitted.

a. Does the State's Administrative Procedures Act apply to the Department of Health, Adult Mental Health Division?

b. Is Title 11, Department of Health, Chapter 175, Mental Health and Substance Abuse System to be considered part of the Rules which fall under the APA?

c. Is it the case that in order for any rule contained in Title 11, Chapter 175 to be changed, such changes must conform to the APA?

d. Is the Department of Health or the Adult Mental Health Division given authority within Chapter 175 to avoid the application of the APA?

e. As regards qualifications of service providers, were there procedures of public notice and public participation for changing the administrative rules of the department within the past 3 years? If so, when were such procedures undertaken and where are the documents available for verification of the taking of such procedures located? Please provide documentation to support your response. If AMHD is not the appropriate body to provide the response, please provide the name of the department that is the appropriate responding State department.

f. Is it the State's view that the Federal law-suit by the Department of Justice and the stipulations entered into in that law-suit provides the Department of Health or the State of Hawaii a legal basis for avoiding the application of the State's Administrative Procedures Act? This question was asked previously relative to HTH 420-2-06. The prior response from the Division was that the Department of Health, Adult Mental Health Division is subject to all applicable and current Administrative procedures. This is not a responsive answer to this question. Please do not circumvent the question but give a simple yes or no answer, clarifying further if necessary.

g. Is the Department of Health's determination to change the requirements for qualification of providers of services for specific services such as case management, individual or group therapy for dual diagnosed consumers, clubhouse services, etc. considered by the Department as a rule change falling under the State's Administrative Procedures Act? If this answer is made pursuant to an attorney general's opinion, please cite said opinion specifically and provide a copy of the opinion.

Response:

a. The Department of Health, Adult Mental Health Division (DIVISION) is subject to all applicable and current Administrative procedures.

b. See response to a., above.

c. See response to a., above.

d. See response to a., above.

e. The public has been provided opportunities to participate in the Department of Health and Department of Human Services rule making process as stipulated by State regulations. Interested parties may ask for documentation from the respective departments.

The qualifications for providers are not always included in rules.

f. See response to a., above.

g. This RFP does not include case management services. The DIVISION is unsure what changes in provider requirements the questioner is referring to and cannot respond to a general question, however rule changes were not required for the services that the questioner referenced that are included in this RFP.

2. Question:

A set of questions was submitted regarding the removal of Case Management Services from the set of services being procured.

a. Please identify the individuals who participated in the decision to remove Case Management Services from the RFP.

b. Please identify all meetings, conferences, conversations and correspondence that discussed and/or determined that Case Management Services were to be removed from the RFP.

c. Please provide copies of all minutes, records, notes, or any information preserved in written, auditory, electronic, visual or other physical form, made by any individual identified in response to a. above.

d. Please identify any email correspondence between or among the individuals identified in A., above related to any discussion, opinion, view-point, or comment on the removal of Case Management Services from the RFP cited above.

e. Please provide a copy of each email correspondence identified in d. above.

f. Please provide any evidence-based research, study, inquiry, or report upon which the decision to remove Case Management Services from the bundle of services which had previously made up Outpatient Treatment, Case Management, and Clubhouse Services for the Wai`anae Coast.

g. Please provide the rational for the removal of Case Management Services from the bundle of services which had previously made up Outpatient Treatment, Case Management, and Clubhouse Services for the Wai`anae Coast.

h. Was there an opportunity for public input in the decision to remove Case Management Services from the bundle of services which had previously made up Outpatient Treatment, Case Management, and Clubhouse Services for the Wai`anae Coast?

i. If so, please provide information on when and where the announcement for such input was made and whether or not the present providers of said services were notified specifically of such input opportunity.
ii. Please also inform if said process were in accordance with Hawai`i's Administrative Procedures Act or the Sunshine law?
iii. Are there any records of such public input?
iv. If so, please provide copies of minutes, notes, memorandum, or other record of such opportunity for public input preserved in written, audio, visual, or electronic form.
v. If there was no opportunity for public input, please explain if the Division is under the opinion that the opportunity for public input was not required.
vi. If so, please provide any and all opinions from the Attorney General's office upon which the Division based its opinion.
vii. The RFP at page 2-17 paragraph 10. A. 1. c. 2) identifies the consumer, psychiatrist, and community based case manager as minimum members of the treatment team. The psychiatrist shall be in charge of the team and have ultimate authority for all clinical decisions. The case manager is responsible for coordinating the development of, communication of the IRP to all providers, and monitor the IRP.
    1. What agency is expected to be responsible for the clinical record of the consumer if the psychiatrist and the case manager are employed by separate agencies?
    2. Are there to be more than one clinical record created in the event the psychiatrist and case managers are from separate agencies?
    3. If there are to be only one clinical record for the consumer, what are the protocols by which an employee from another agency is to gain access to said clinical records?

4. If more than one clinical record is to be created, depending on the number of agencies who have employees on the treatment team, how is the information from one clinical record to be updated in the other clinical records?
5. For purposes of quality assurance, what agency will be expected to monitor the quality of the clinical records?
6. What agency will be expected to be the primary agency for reporting sentinel events?
7. Who, among the members of the treatment team, assuming that members work for different agencies, have the right to call a team meeting? Who undertakes responsibility for notifying team members across agencies of treatment team meetings?
8. Will the case manager be responsible for obtaining authorizations for services by the psychiatrists, psychologists, nurses, or clinicians?
9. If a case manager fails to obtain authorization for a psychiatrist's reevaluation of a consumer determined by the psychiatrist to be necessary, shall the psychiatrist be expected to apply for the authorization?

Response:

Regarding questions a. – g., case management is not included in this procurement and will not be addressed in this question and answer. A separate case management RFP has been released and questions regarding that RFP should be asked related to that procurement.

Regarding questions h. i.-vi., a Request for Information was published in February, 2006. There was one responder to the RFI. The responder expressed strong concerns about the decision to exclude case management services from the RFP. The responder also objected to the requirement that care coordination be provided by professional staff such as psychiatrist, social worker, psychologist, Registered Nurse, or Advanced Practice Registered Nurse. The responder provided detailed information on the difficulties of hiring and retaining professional staff in the Waianae community and the necessity to provide competitive compensation. The responder is providing services in the Wai`anae community and provided useful information on its community based and culturally specific procedures and capabilities.

DIVISION staff based their decisions on staff qualifications on their knowledge of requirements in the Hawaii service system and their ongoing interaction with programs and service providers. The decision to solicit case management services separately was based on the DIVISION's desire to establish and support a uniform level of case management services throughout the State.

Regarding questions h., vii., please see below:

1. Each agency is responsible for providing documentation related to their provision of services.

2. Yes.

3. The consumer may be asked to sign a consent in accordance with HIPAA and State privacy laws.

4. See question vii., 1., above.

5. Every agency is responsible for monitoring their own records. AMHD will also do an annual review as part of the contract monitoring process.

6. Any agency who has knowledge of the sentinel event must report it in accordance with the DIVISION's Sentinel Event Policy and Procedure.

7. Any member of the treatment team can request a meeting. The individual who is requesting the meeting is responsible for notifying the other members.

8. No, per the revised Utilization Management program. Applicants are advised if this process were to change, providers would be required to follow any new directives.

9. See #8 above.

3. Question:

A question was submitted regarding the management of the Outpatient and Clubhouse services to be provided and whether or not the specific rules or requirements were properly adopted by the Department of Health.

The questioner notes several requirements in the RFP including: prior approval before presentation of reports and presentations, prohibitions on advertising, distributing or providing any material relating to the contract to the consumer without DIVISION approval, limitation of services to persons with severe and persistent mental illness, the fee schedule, the role of a psychiatrist, and clubhouse operations.

The questioner asks if these new procedure, rule and practice requirements have been previously subjected to public input? The questioner asks for "information as to when and where public notice was published, and the minutes, records, memoranda contained in written, audio, visual, or electronic form of such opportunity for public input."

Response:

The requirements presented in the RFP do not constitute rule changes requiring public input.

4. Question:

At page 2-6, Para. 8, of the subject RFP, applicant is required to obtain Division's prior approval before presentation of "any report or statistical or analytical material based on information obtained through this agreement."

a. How does the Division define "information obtained through this agreement?" Does it include statistical information reported to a court? Does it include our quality assurance team's report at our utilization review team meeting? Does it include analytical material that we provide to a funder or potential funder, to an accrediting team, or to an audit authorized or required by law? Does this include the information we would normally include in our Annual Report to the community? Does it include a governmental investigation? Does it include a discovery request made in a lawsuit? Does it include any report or testimony to the Legislature? "The General Conditions on the SPO website" does not clearly enough answer the specific questions here. If a reference is made by the Division to another information source, please site the paragraph or section of said information source specifically.

b. Does the Division take the attitude that the records obtained as a result of a contractor providing service under such an Outpatient Contract to be the property of the Division? If so, under what legal provision is this position taken? "The General Conditions on the SPO website" does not clearly enough answer the specific questions here. If a reference is made by the Division to another information source, please site the paragraph or section of said information source specifically which responds to my questions.

Response:

The General Conditions at 2.1 Confidentiality of Material require that

> All material given to or made available to the PROVIDER by virtue of this Agreement that is identified as proprietary or confidential information shall be safeguarded by the PROVIDER and shall not be disclosed to any

individual or organization without the prior written approval of the STATE.

Pursuant to this provision, and to ensure confidentiality of patient information and other confidential information, the DIVISION requires written approval of statistical and analytical information.

5. Question:

At page 2-6, of the RFP, Para. 8, requiring prior approval of the Division of presentations by the applicant, to the presentation of any report or statistical or analytical material based on information obtained through this agreement, it states, "Formal presentation shall include, but not limited to papers, articles, professional publications, and presentations." Does the Division declare that the applicant is not to publish papers, articles, etc. using statistical information which may include service to the SPMI under this service contract, without the State's prior review & consent? Why is the State imposing such a censorship condition to such a contract? Is there a statutory or regulatory basis upon which this condition is being imposed? If the Division is not interested in censoring professional discourse or invading the freedom of expression of the applicant, why has it included this provision in the RFP? Please be mindful that this question asks for a response broader than the use of aggregate information for presentation.

Response:

The applicant may use aggregate information for presentation without prior approval. The DIVISION has no interest in censoring professional discourse.

6. Question:

Page 2-6, of the RFP, Para 8, part 2. prohibits applicant from advertising, distributing or providing any material relating to the contract to the consumer unless approved by the Division. Division is further required to approve all consumer satisfaction surveys and methodologies, prior to implementation. Please be responsive to the specific questions asked below, rather than giving a self-serving justification which has no basis in law.

Is it not part of a consumer's right, the right to information of who is paying his cost for mental health treatment? If so, why do we need permission from the Division in order to provide consumer his rights? We believe that this is an encroachment upon the statutory and constitutional rights of both the consumer and the provider and an area where the Division has no legitimate right to enter. Please cite any statutory or constitutional basis upon which the Division relies for attempting to regulate the communication between provider and consumer. If the

Division has relied upon an Attorney General's opinion, please cite the opinion and provide a copy of said opinion.

a. What is the basis upon which the Division has determined to deny, restrict or limit the flow of information from the contractor to the consumer? Is this not a denial of substantive rights of both the contractor as well as the consumer?

b. Sometimes, censorship masks as government's regulatory role in preventing inaccurate, false, or misleading information from being spread. Why has the division taken the approach that it must act in such a regulatory role?

Response:

The intent is to ensure the consumer receives the accurate information he or she needs to make an informed decision when choosing a provider. Marketing information should not mislead or confuse consumers and should not contain inaccurate, false, or misleading statements. Consumer satisfaction surveys must be reviewed by the DIVISION prior to implementation to ensure the surveys are fair and impartial, meet survey standards, and will result in usable information to measure the quality of services as ascertained by the consumers. The provider shall maintain the provider-patient relationship with each consumer and shall be responsible for the care and treatment of the consumer. Nothing in this RFP is intended or shall be interpreted to: (a) interfere with the provider-patient relationship, (b) discourage or prohibit a provider from discussing preventive or treatment options, or (c) discourage or prohibit a provider from providing other medical advice or treatment deemed appropriate.

7. Question:

Page 2-6 to 2-7 of the RFP, Para. 9. f. requires applicant to respect and uphold consumer rights. Para. 9. k. requires the applicant to maintain confidential records on each consumer. Para. 9. k. also declares, "Such records shall be made available to the Division upon request." That last sentence is a direct violation of confidential laws that the division has cited. Records can only be disclosed pursuant to specific exceptions of the laws on confidentiality. There is no exception for the production of records merely based upon the Division's request! Will the Division abide by the requirements of the laws of confidentiality in seeking to obtain confidential records of consumers? If the Division claims that it has a legal right in its oversight capacity under Federal law to access records. Please provide the statutory or regulatory basis upon which the Division relies, being specific and providing the appropriate Federal citation. Please also provide any statutory basis upon which the Division declares it has a right to impose a daily fine for failure of the provider to produce such records upon the mere request of the Division.

Response:

The DIVISION has a legal right in its oversight capacity to access records.

The DIVISION has the responsibility and authority to ensure that contractual requirements are met.

8. Question:

Question: Page 2-8, Para. 10. c. deals with eligibility of services and requires at 3) *"Have severe and persistent mental illness, be in a state of crisis (short-term services), be victims of natural disasters and terrorism, or court ordered for treatment by the Division.)* The Surgeon General's earlier report on Mental Illness classified adult mental disorder into three categories: any mental illness (MI), serious mental illness (SMI), and severe and persistent mental illness (SPMI). These classifications are based on significant functional impairment. (See p. 4, AMHD publication, Mental Illness in Hawai`i: Prevalence Estimates Based on Year 2000 Census, Aug 24, 2004, Tech. Report No. 040824) AMHD has recited Federal definition (ibid at pp. 4 – 5) which explains that "*SMI includes serious anxiety, and mood disorders (not including bipolar disorder). About half of those with SMI, or approximately 2.6% of adults 18 years and older, are estimated to be even more seriously affected, that is, living with "severe and persistent" mental illness (SPMI). This category includes schizophrenia, bipolar disorder, and other non-affective disorders*."
State law, HRS 334-2, uses the broader term "mental or emotional disorders" which presumably covers all three of the Federal classifications.
It states: *The department of health shall foster and coordinate a comprehensive mental health system utilizing public and private resources to reduce the incidence of mental or emotional disorders and substance abuse and to treat and rehabilitate the victims in the least restrictive and most therapeutic environment possible.*

a. Is it not the case that the Department of Health is charged with responsibility to treat and rehabilitate those who fall within the broader definition of mental or emotional disorders, and not just the "severe and persistent" mentally ill? If so, does the Department of Health through AMHD, by limiting the scope of services to only the SPMI, fall short of the department's obligation under HRS Section 334-2?

b. As used in the subject RFP, how does SPMI differ from SMI in clinical terms? Is the division using the Federal definition?

c. If not, is the definition of SPMI a "floating" definition subject to change during the contract term depending on new criteria created within AMHD?

d. If those now to be treated under the Outpatient contract described by the subject RFP are limited to SPMI, what happens to those who need services but are merely SMI? Who will service the SMI or those suffering from other mental or emotion disorders?

e. Recognizing that the "Plan for Community Mental Health Services" in USA v. State of Hawaii, Civil No. 91-00137, November 27, 2002 also engages in definitions, is it the Division's position that the plan overrides the statutory obligation found in HRS 334-2 for the Department of Health or is the plan additive to or explanatory of the department's obligation, enlarged to incorporate Federal requirements?

Response:

The definition of SPMI is from the "Plan for Community Mental Health Services, "USA v. State of Hawaii, Civil No. 91-00137, November 27, 2002. The population to be served under this RFP must meet AMHD eligibility guidelines. It is preferable for providers to focus on the diagnosis and functionality of each individual consumer rather than a general population label.

9. Question:

RFP at page 2-16, para. 1. restricts referrals only from Division Access line. Please clarify that this limitation is only for purposes of billing for assessments to the Division. Our services shall still remain available for non-Division consumers and who may be referred through a number of sources.

Response:

The requirements of the RFP apply only to AMHD consumers.

10. Question:

RFP at page 2-9, paragraph 10. d., first paragraph describe education provided by the Division and the notification requirements of the case manager to the applicant as well as the consumer's obligation to report changes to the case manager and/or provider. Elsewhere in this paragraph as well as in the following paragraph, both the terms applicant and provider are used without any clarity as to the difference between the two terms. Who is the "provider" if not the applicant in these two paragraphs?

It is our experience that the consumer is generally in much closer relationship with the case manager than the clinical staff. More timely information regarding change in the consumer's status is passed to the case manager than to the psychiatrist or clinician. Is it not the case that the case manager should be the

party primarily responsible for obtaining information as set forth in paragraph 10.e. from the consumer? Is it not the case that the case manager should be the party primarily responsible for informing Utilization Management of the changed information? Who has primary responsibility for the transfer of information received from the client? If both the clinical/somatic service providers and the case managers are charged with these duties, is the division serious about wanting to receive duplicative information?

Response:

The terms "applicant" and "provider" have the same meaning. "Applicant" is the term used in RFPs for persons who may apply in response to the RFP. "Provider" is the term used in contracts for that party with whom the DIVISION is contracting. The RFP should have used the term "applicant" throughout.

11. Question:

RFP at page 2-16, Paragraph A. 1. a., calls for providing a "standardized mental health assessment" of individuals referred by the Division's Access Center. In referring to the Fee Schedule found at page 2-35 of the RFP, I can find no reimbursement rate for a "standardized mental health assessment."

a. Please identify the Procedure Code and individuals qualified to provide such "standardized mental health assessment."

b. If such assessments are not already described in the Fee Schedule, will the division reimburse for such services when not paid for by third parties, and if so, at what reimbursement rates? What is the expected length of time for such assessments?

c. If not already described in the Fee Schedule, what are the qualifications of individuals who shall complete such assessments?

Response:

a. The 90801 Procedure code is to be used for a standardized mental health assessment. The billing rate is included in the RFP. Only Qualified Mental Health Professionals can use this code.

b. As the assessment is included in the fee schedule, the usual requirement for third party billing apply as the Division is the payer of last resort. There is no standard length of time allotted for assessments.

c. See Question 11.a.

12. Question:

RFP at page 2-16 and 2-17, Paragraph A. 1. b. calls for providing and completing an "intake assessment" for each consumer referred. In referring to the Fee Schedule found at page 2-35 of the RFP, I can find no reimbursement rate for a "intake assessment."

a. Please identify the Procedure Code and individuals qualified to provide such "intake assessment."

b. If such assessments are not already described in the Fee Schedule, will the division reimburse for such services when not paid for by third parties, and if so, at what reimbursement rates? What is the expected length of time for such assessments?

c. If not already described in the Fee Schedule, what are the qualifications of individuals who shall complete such assessments?

Response:

See response to Question 11.

13. Question:

Question: RFP at page 2-16, paragraph 3 calls for providing each consumer with a master recovery plan (MRP).

a. Who on the treatment team is charged with the responsibility of writing the MRP?

b. What is the procedure code(s) and the level of service provider for completing a master recovery plan? (Please note that this is not reflected specifically in the fee schedule attached to the RFP.)

c. What is the expected length of time for the preparation of such a master recovery plan? (Please do not refer us to a "national coding manual" as such a reference is not helpful, such manuals may not be uniform, and we may not have such a manual to refer to.)

d. Will each member of the team be able to bill for participating in the development of such a master recovery plan? If so, please specify the appropriate procedure code and level of service competency.

Response:

a. The treatment team is responsible for the MRP. The team should decide who on the team will be responsible for writing it.

b. There is no separate payment under this RFP.

c. Please refer to the AMHD policy number 60.648 on Recovery (Treatment) Planning. It can be found on the Divisions website www.amhd.org.

d. No.

14. Question:

The RFP at page 2-17, paragraph III. A. 1. C. 2) identifies the Psychiatrist as the person in charge of the treatment team and having ultimate authority for all clinical decisions. A stipulation made in the DOJ lawsuit requires the Psychiatrist to be that lead person, but the language restricts that requirement only to State operated Community Mental Health Centers. We believe that this requirement should not apply to a non-state operated center. There are circumstances in which the psychiatrist may be needed for his signature on the master treatment plan for reimbursement reasons. But the real person in charge of the recovery plan and who should have "ultimate authority" for all clinical decisions should be the consumer. Oftentimes, we find the case manager or clinician on the team being the most informed with respect to the needs of the consumer. We believe that the treatment team is better when operated by consensus of the team members while regarding the consumer as having the final determination of the plan itself. We also believe that the psychiatrist who is overseen by the Medical Director should be the principle informant as regards issues that are medical in nature. Clinical issues should involve especially the clinician who operates under the Clinical Director. Those aspects of the Master Recovery Plan which regards the consumer's employment goals, education goals, family reconstruction goals, and other recovery goals should receive the input of those team members most informed of those areas.

It appears that for a community provider of services working in the Wai`anae community, it would be more appropriate to approach the treatment team's organization from one of consensus among all team members as opposed to the top-down medical model. This is "experience based" and we therefore request the Division reconsider this requirement.

a) What is the basis upon which the Division has determined that the psychiatrist may overrule the consumer in the development of the consumer's Master Recovery Plan?

b) What is the basis upon which the Division has determined that non-state operated community mental health centers need also conform to the determination that a psychiatrist is necessarily the final voice in the formation of a Master Recovery Plan?

c) Is this determination one that is covered by the Administrative Procedures Act or more generally the Hawaii Sunshine law?

d) If the answer to c. above is Yes, please provide the public notice which had been given of the adoption of this administrative decision, the date and time set for a public hearing on this matter, as well as the minutes or record of such meeting.

e) If the answer to c. above is No, please provide the statutory, regulatory, A.G. opinion, or other specific basis upon which a determination has been made that this decision does not fall under the APA or the Hawaii Sunshine law.

Response

The psychiatrist shall be in charge of the treatment team and have ultimate authority for all clinical decisions. All members of the treatment team should be involved in the development of the plan with the consumer.

The Community Plan is not limited to the performance of the Community Mental Health Centers.

15. Question:

A questioner noted that the RFP at page 2-18 references "community based case management" and had several questions.

a. How is "community based" defined relative to the community of Wai`anae?

b. Does the division require that the case manager be from the community of Wai`anae?

c. Does the division require that the organization providing case management services be based in the Wai`anae community?

d. Does the division require that the case manager live in the Wai`anae community?

e. Does the division require that the case manager be assigned primary responsibility out of the Wai`anae community?

f. Does the division require that the case manager be trained in the cultural practices generally adhered to in the Wai`anae community?

g. Does the division require that the case manager be trained in the social and economic milieu of the Wai`anae community?

Response:

Within the context of services to the Wai`anae community, community based case management services should understand, be sensitive to, and responsive to the demographic and social conditions of the local community. While none of the conditions stated in b. through g., above are required, they would all lend strength to the case management effort.

16. Question:

The RFP at page 2-18, para. e. 2) calls for treatment that combines interventions directed simultaneously to both mental illness and substance abuse for those consumers with both conditions. In the event the consumer is in denial of one or another condition, or simply refuses to obtain treatment for one condition, e.g., alcoholism, will the Division allow treatment limited to only what is consented to by the consumer notwithstanding the fact that the psychiatrist insisted on a MRP which called for treatment for substance abuse? To what extent shall clinical services be provided a consumer who refuses substance treatment but is willing to accept only mental health treatment?

Response:

Part of engaging with consumers who are in denial of their illness (despite which one) is building a relationship and assisting the consumer to come to an awareness of the illness. The consumer who is unaware of their illness must be engaged in a long-term treatment relationship which seeks to increase their understanding of how their illness impacts their goals.

17. Question:

The RFP at page 2-18, para f. 1) Somatic Treatment limits the service to be provided only by a licensed psychiatrist or APRN in behavioral health. Included in the service is medication monitoring and administration services provided by an RN.

a. Can’t medication monitoring and administration services also be performed by an LPN or a Medical Assistant, overseen by an RN? If not, why not?

b. Are these limitations upon an LPN or a Medical Assistant based on currently established professional standards or prescribed in state law or Department of Health rules?

c. What are the reimbursement codes and rates for medication monitoring?

d. What are the reimbursement codes and rates for administration services?

Response:

a. Medication administration can be performed by a Registered Nurse, Licensed Practical Nurse or a Medical Assistant all of whom must be licensed in the State of Hawaii and be under the supervision of a physician or registered nurse. Medication monitoring by a Registered Nurse is considered an administrative expense and there are no separate billing codes or reimbursements for this service.

b. The staff is required to work within their scope of practice.

c. Refer to the fee schedule. 90862 Medication Management can be performed by the Psychiatrist or APRN with prescriptive privileges**.**

d. Refer to the fee schedule under Clinic Services.

18. Question:

Page 2-19 at para 4) Family Therapy. Family psychotherapy codes 90846, 90847, 90849 contain no time frame. The fee schedule for these procedure codes also do not contain a time frame. What is the expected number of minutes for each of the above coded services? Please do not refer me to yet another document or manual for this response as I may not have such manual available, including the "Current Procedural Terminology".

Response:

Providers are required to chart the beginning and end time for these services in the consumer's progress notes. Generally these services are provided for 45-50 minutes.

19. Question:

Collateral contact services, either face-to-face or by telephone does not appear as a billable activity. If case management is not included as part of this contract, the people providing the somatic treatment as well as individual therapy will have to provide collateral contact services in order to be effective in their services. What is the procedure codes for such services and what is the rate of reimbursement?

Response:

Collateral contacts are part of the cost of providing services and are not billable separately.

20. Question:

Question: Page 2-19, Care coordination services. This service appears to have eliminated peer counselors as well as community members without a bachelor's degree. We protest this exclusion of peer specialists, community people with only high school degrees or community people who have practiced in this field for years.

a. What was the process taken by the Division in setting forth the minimum qualification for one providing care coordination services?

b. Was this process achieved within the requirements of the Administrative Procedures Act?

c. Who participated in making the decision setting forth the minimum qualification for this service?

d. Was there a public hearing prior to the decision on the minimum qualifications for this service? If so, when was it held? Please provide a copy of the minutes or record of such a hearing as well as the discussions held among the decision makers which resulted in the making of such decision.

e. If not in accordance with the APA, what is the legal basis upon which AMHD have adopted this criteria for care coordination services?

f. Peer Counselors can play a critical role in providing care coordination services. Why are they not provided the opportunity to provide such services?

Response:

The decision to set personnel standards for these services was made by DIVISION staff based on their knowledge of requirements in the Hawaii service system and their ongoing interaction with programs and service providers. These decisions do not constitute rule making within the meaning of the Hawaii Administrative Procedures Act.

As noted in the response to Question 2., above, a Request For Information was held in February, 2006. A responder expressed strong concerns about the requirements for care coordination staff.

Although the RFP requires professional staff rather than peer specialists for care coordination, paragraph i on page 2-20 of the RFP calls for peer specialists to perform a wide range of tasks.

21. Question:

Page 2-20, paragraph i. Calls for Peer Support Services. Referring to the fee schedule, there are no procedure codes or reimbursement rates for peer support specialist as they provide their array of services as set forth in paragraph i. Is the provider of services expected to provide the peers support specialist services for free or was this an oversight by the division? If an oversight, what are the procedure codes and reimbursement rates for peer support specialist services?

Response:

The certified peer specialist will be reimbursed through cost reimbursement rather than through a unit of service rate. Please refer to RFP Section 2, III.,B.,9.,b. on page 2-34.

22. Question:

Page 2-20 describes forensic coordinator services and mental illness/substance abuse coordinator services. Page 2-34 b. describes the pricing structure for Certified Peer Specialist, forensic coordinator and MI/SA coordinator. That page states that any "direct service time is to be billed on the fixed unit of service rate" A referral to the fee schedule does not reflect procedure codes and reimbursement rates for all three services. What is meant by "direct service time" as applied to these three positions and what are the procedure codes and fees to be paid for said time?

Response:

The MI/SA Coordinator and the Forensic Coordinator should be budgeted for the specific percentage of their time that will be spent on coordination activities. This will be reimbursed by cost reimbursement. In addition to the time spent on coordination functions, these two staff also provide any other "direct services" for which they are qualified and which are identified on the Fee Schedule. These direct services will be reimbursed by fixed unit of service rates.

For example, the MI/SA Coordinator may be budgeted for 20% of his/her time as Coordinator. When not functioning in the coordinator role, he/she also provides assessments, individual, and group therapy. He/she would be reimbursed for coordination functions through cost reimbursement and for assessment and therapeutic functions through fixed unit of service rates.

23. Question:

Clubhouse program calls for direct supervision of a mental health professional. Yet clubhouse philosophy is directed toward addressing the social, employment, cultural, and other interactive needs which make up a well-rounded life of a consumer/member. There has been a major drive to separate the clinical/somatic treatment aspect of mental health services from the social-cultural-employment transition development of a member. That separation is to occur, as much as possible, at clubhouses.

a. While we can appreciate involvement of a mental health professional within a clubhouse setting, we do not see the appropriateness of a direct supervision role by that mental health professional. We ask the Division to reconsider the call for such direct supervision language made in the RFP as going against the ICCD philosophy as well as the direction of the Wai`anae clubhouse. Furthermore, if the direct supervision role of a mental health professional is mandated, the clubhouse program will not be able to function at the reimbursement rate provided for in the fee schedule.

b. Is the mental health professional a staff member of the clubhouse or is that MHP merely the supervisor over the staff of the clubhouse?

c. Is this MHP expected to be physically on the site of the clubhouse during the regular operating hours of the clubhouse program, or may the MHP drop in and observe, as well as supervise as necessary, the staff generalists?

d. Page 2-22 at paragraph d) & e) the RFP identifies the staff in specific roles, such as "shall lead structured, scheduled activities" or "shall engage in employer outreach to develop transitional and supported employment . . ." If Clubhouse is to emphasis an egalitarian approach to its management, why does the RFP identify the staff in such leadership roles, and detract from the possibility of members taking such leadership roles?

e. What are the record keeping or record maintenance requirements for the clubhouse? Are progress notes required? Are consumer members privy to the billing records for clubhouse activities? Are such records to be maintained in secured areas not open to all members? Should such records be maintained at another site? May such records be maintained as another site?

f. Clubhouse representation on treatment team recovery planning meetings are called for. Such attendance can be time-consuming as well as individualized, as compared to group-billed. What are the procedure codes and the reimbursement rates for attendance as such meetings as none appears in the RFP fee schedule.

g. How will Division UM authorize attendance at clubhouse?

h. Will the clubhouse staff be expected to secure authorizations from the Division or will Division provide a blanket authorization for clubhouse participation?

i. If authorizations from the Division is required and not provided by the Division, does this mean that clubhouses may reject or should reject members or new member applications?

j. Does this mean that clubhouse membership is now to be determined by UM as opposed to the existing members of each clubhouse?

k. While staff only or member only space is not permitted at a clubhouse, can space be limited only for certain identified staff and members? For example, due to safety reasons in a work area that may contain power machinery, can such space be limited only to members and staff specifically assigned to that project?

l. At p. 2-21, member to staff ratio is set as no greater than twenty members to one staff person. Are the members who are counted active members or are they total clubhouse membership?

Response:

a. At a minimum, this RFP requires that the clubhouse director, if he/she is not a mental health professional, receive supervision from a mental health professional. This may be fulfilled by regularly scheduled meetings between the director and the mental health professional. The supervisor is not required to be on the clubhouse staff or provide on-site supervision.

b. The mental health professional is not required to be on the clubhouse staff.

c. The mental health professional may supervise the clubhouse director on-site or off-site.

d. The delineation of clubhouse staff responsibilities in this RFP should not be taken to mean that clubhouse members are to be excluded or discouraged from taking on such responsibilities themselves in the egalitarian clubhouse community. The RFP identifies roles Clubhouse staff are required to fulfill. The RFP does not discourage the active promotion of Clubhouse members engaging in such leadership roles themselves. The philosophy and intent of Clubhouse programs is to maximally encourage such initiative and leadership among its membership.

e. Clubhouses are expected to follow ICCD guidelines regarding member records. Clubhouses keep records related to Clubhouse member tracking, referrals, and development/implementation of members' individual rehabilitation goal plans, including, at a minimum, monthly progress notes that members co-write or minimally co-sign with staff. The current record keeping standard

practice for statewide Clubhouses is monthly progress notes and semi-annually updated member rehabilitation plans. Service documentation should be at the service site. Administrative records may be at another site.

f. A billing code has not been established but will be considered.

g. Per current Utilization Management Policy and Procedure, the clubhouse agency will notify UM within thirty (30) days of the start of services and receive an authorization.

h. Clubhouse staff will have to receive authorization for each consumer. A consumer may request a copy of billing records.

i. The DIVISION makes payment decisions only.

j. See response to Question 23. i., above.

k. Clubhouses are expected to follow ICCD guidelines and seek ICCD clarification of such issues. In general, staff and member opportunities for access to Clubhouse resources are to be equal, even though in specific, limited circumstances, access may be contingent upon receiving and/or maintaining specified training, safety education and/or competencies that are available to all.

l. The maximum 20:1 ratio of clubhouse members to staff is based on active clubhouse members (i.e., those who have attended clubhouse at least once in the previous 30 days).

24. Question:

Attachment F contains the definition of a QMHP. Why is the licensed mental health counselor not included as a QMHP if it is recognized as a licensed professional? Does the DIVISION intend to recognize this licensure?

Response:

The Division is working with the Department of Human Services to designate Licensed Counselors in mental health as QMHP. Until a State Plan Amendment with this addition is approved by the Centers for Medicare and Medicaid Services, the current definition will be in effect.

25. Question:

Page 2-27, paragraph g. requires all staff receive appropriate and regular clinical and administrative supervision at least once a month. Why is the division

requiring such clinical supervision from the clubhouse staff if clubhouse is not supposed to be a clinical program?

Response:

Clinical supervision is not required for clubhouse staff. Administrative supervision is required for clubhouse staff.

26. Question:

At page 2-28, 2. b. it is stated that the applicant "shall accept all referrals deemed appropriate by the Division's utilization management process." This is a deviation from clubhouse practice where members make the final decision as to whether or not an applicant to clubhouse is appropriate and accepted. Does this RFP require that the existing practice within Hui Hana Pono clubhouse be changed to be in accord with the RFP requirement?

Response:

Utilization management makes payment decisions.

27. Question:

Question, Page 2-28, Section 2, III, B., 2., d. This section states that' "All consumers shall be registered for services and have a record open with the DIVISION'S information system."

a. Would it be more appropriate for the section to identify this as a requirement specifically for those whose services will be paid for by the DIVISION?

b. Does the DIVISION intend that individuals whose services are being billed to a third party and not being reimbursed by the DIVISION also have their data sent to the DIVISION? Would this not be a serious breach of confidentiality and in violation of both state and federal law?

Response:

This RFP and contractual requirements refer only to AMHD consumers.

28. Question:

Question regarding reimbursement rates: The rates for Psychiatrist services 90801, 90806, 90847, 90853, and 90862 appear to be far below the standard rates in the Hawaii community. For example, both Medicare and HMSA pay $147.62 and 158.35 respectively for 90801 services which the State is offering a reimbursement of only $119.24. In the case of procedural code 90806, Medicare

and HMSA pays $97.32 and $123.40 respectively for services reimbursed by the state at only $81.53.

a. Why doesn't the AMHD rates reflect the prevailing rates in the community?

b. Are the psychiatrists employed by the State at the Hawaii State Hospital or at any of the State's community mental health centers paid salaries based upon computations taking into account these unit rates?

c. What are the ranges of salaries for the position of Psychiatrist employed at the State's community mental health centers and the State Hospital?

d. What are the starting salary ranges for such positions?

e. What are the incremental salary steps being paid for Psychiatrists by the State at the Hawaii State Hospital and at the State's community mental health centers?

Response:

a. The rates provided by AMHD are exactly the same that HMSA QUEST pays the CMHCs for their services.

b. HSH and CMHC psychiatrist salaries do not take into account payments by third party payers as they have a public health mission to provide services to all those who are eligible for services.

c. The salary range for Psychiatrist positions is $109,164 to $119,904.

d. The starting salary range for Psychiatrist positions is $109,164 to $119,904.

e. There are no incremental salary steps for the Psychiatrist position.

29. Question:

The rates for Licensed Clinical Psychologists services appear below the standard rates in the Hawaii community. The rate for 90804 suggested by the RFP is $53.24 while that same procedure code is being reimbursed by Medicare at $62.99 and by HMSA at $77.15. The rate for 90845 suggested by the RFP is $81.69 while that same procedure code is being reimbursed by Medicare at $98.28 and by HMSA at $111.60.

a. Why doesn't the AMHD rates reflect the prevailing rates in the community?

b. Are the licensed clinical psychologists employed by the State at the Hawaii State Hospital or at any of the State's community mental health centers paid salaries based upon computations taking into account these unit rates?

c. What are the ranges of salaries for the position of licensed clinical psychologists employed at the State's community mental health centers and the State Hospital?

d. What are the starting salary ranges for such positions?

e. What are the incremental salary steps being paid for licensed clinical psychologists by the State at the Hawaii State Hospital and at the State's community mental health centers?

Response:

a. The rates provided by AMHD are exactly the same that HMSA QUEST pays the CMHCs for their services.

b. HSH and CMHC psychiatrist salaries do not take into account payments by third party payers as they have a public health mission to provide services to all those who are eligible for services.

c. The salary range for licensed clinical psychologists is $49,572 to $79,368.

d. The starting salary range is $49,572 to $55,764.

e. The incremental salary steps range from 3.952% to 4.0168%.

30. Question:

The rates for therapeutic Injection, procedure code 90782 appears to be far below the standard rates in the Hawaii community. The State in this RFP is offering to pay $5 while HMSA reimburses for this service at $12 and Medicare, at $19.83. Why is the rate so much lower in the State's RFP offer than HMSA and Medicare?

Response:

The rates provided by AMHD are exactly the same that HMSA QUEST pays the CMHCs for their services.

31. Question:

What are the prevailing pay rates being offered by the State of Hawaii at the State Hospital and at the State operated community mental health centers for Certified Peer Specialists, Forensics Coordinator and MI/SA Coordinator?

Response:

The prevailing pay rates being offered are $25,764 for the Certified Peer Specialist, $60,288 for the Forensic Coordinator, and $45,840 for the MI/SA Coordinator.